STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085029	A. BUILDING _____ B. WING _____	C 08/09/2012

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HARRISON SENIOR LIVING OF GEORGETOWN, LLC	110 W. NORTH STREET GEORGETOWN, DE 19947

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F 000	INITIAL COMMENTS An unannounced complaint visit was conducted at this facility from August 6, 2012 through August 9, 2012. The deficiencies contained in this report are based on observation, interviews and review of residents' clinical records and review of other facility documentation as indicated. The facility census the first day of the survey was one hundred and twenty-one (121). The survey sample totaled twelve (12) residents.	F 000	Disclaimer: Preparation and/or execution of the plan of correction does not constitution an admission or agreement by the provider or the provider's employees as to the truth of the allegations in the Statement of Deficiencies. The Plan of Correction is offered in mandatory compliance with the provisions of state and federal law. The corrective actions are implemented as remedial measures pursuant to law. **Date of Compliance 9/11/2012**	
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of	F 157	**F tag 157 Notify of Changes** **1. Corrective actions for affected resident** -Upon identification of error by administrative nurse, MD was promptly notified of error on April 29, 2012. 4/29/12 - Disciplinary action was taken with day staff involved in failing to notify physician of medication error. 5/1/12 -Disciplinary action was taken with night shift staff who did not verify order changes upon residents return from hospital 5/8/12 -All licensed staff was in-serviced on medication errors and how to prevent them following incident 5/3/12	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Carole Daniels | Administrator | 8/28/12

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 157	Continued From page 1 this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that for one (R6) out of 12 sampled residents the facility failed to notify the physician of a significant medication error that resulted in a significant change in the resident's status. Findings include: The facility's policy and procedures for "Medication Errors" stated "when it is determined that a medication error has occurred,... A. Notify the physician." Cross refer F333 R6 was admitted to the facility on 4/25/12 with diagnoses that included dementia, chronic obstructive pulmonary disease and diabetes mellitus. On 4/28/12 at 1:30 AM R6 returned from the hospital after being treated for a hypoglycemic episode after receiving the wrong dose of Lantus insulin. R6 had a discharge instruction to decrease the Lantus to Lantus 10 units sub-q. On 4/28/12 at 7:30 AM R6's MAR documented that R6 was administered Lantus 40 units instead of Lantus 10 units. Review of R6's physician order sheet revealed	F 157	**2. Identification of other residents** Audits are being completed on all admissions/re-admissions to determined that no other residents have been affected **3. Measures/System changes** -Facility will re-inservice licensed staff on facility policy and procedure r/t medication errors -Medication errors added to new hire orientation -Assigned nurse will ensue any resident returning from hospital or outside facility with change in orders will have orders verified with PCP promptly **4. Monitoring** -Unit Managers /Supervisors will ensure all orders are verified by the PCP promptly and PCP is notified of any medication errors immediately. -Concerns will be reported at morning meeting via 24hr report.	5/2/12 9/11/12 5/15/12 5/3/12 9/11/12

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F 157	Continued From page 2 that on 4/28/12 at 1:40 PM (over 12 hours after R6's return to the facility from the hospital and over 6 hours after R6 was administered Lantus 40 units sub-q) the facility received an order for Lantus 10 units sub-q at 7:30 AM. Review of R6's record failed to have evidence that the facility notified the physician that R6 was administered the wrong dose of Lantus. Review of E9 (RN supervisor) and E10's (LPN) written statements revealed they were aware that R6 received the wrong dose of Lantus that morning. Both E9 and E10 documented that they failed to notify the physician of this medication error that lead to R6 being sent to the hospital on 4/29/12 and diagnosed with "Diabetic hypoglycemia with diabetes mellitus type II." On 8/9/12 at 11:00 AM the above mentioned findings were reviewed and confirmed with E1(administrator), E2 (DON) and E3 (ADON).	F 157	**F309- Providing care and services** **1. Corrective action for resident identified** In-servicing conducted with involved staff at time of incident **2. Identification of other residents** Review of falls for past 30 days will be conducted to ensure no other residents were affected. **3. Measures/System changes** - Secondary to E11 being a new CNA, new hire orientation program has been updated to include facility policy on falls and education on not moving resident until assessed by licensed nurse -All Facility staff will be in-serviced on the importance of not moving resident until assessed by nurse **4. Monitoring** -As part of regular incident reviews, will monitor for any occurrences of staff moving resident before he/she has been assessed by licensed nurse. -Results will be reported at monthly QA	5/24/12 9/11/12 6/5/12 9/11/12 9/11/12
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on record review, review of other facility documentation and interview it was determined	F 309		

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F 309	Continued From page 3 that for one (R9) out of 12 sampled residents the facility failed to provide the necessary care and service in accordance with the comprehensive assessment . R9 fell on the floor and was picked up and put back in her chair before being assessed for injury by a nurse. Findings include: The facility's policy and procedure for "Resident Falls" (2) Resident Fall The resident will not be moved from the floor until assessed by a licensed nurse." R9 was admitted to the facility on 10/26/11 with diagnoses that included right hip arthroplasty, atrial fibrillation, hypertension, cerebral vascular accident trans-ischemic attacks , hypothyroidism, anemia, depression, anxiety, non-Alzheimer dementia, and psychosis. Review of R9's nurses notes dated 5/23/12 at 1:45 PM revealed at approximately 10:10 AM a CNA found R9 on the bathroom floor. R9 fell out of her wheelchair and the resident stated she hit her head but denied pain initially. Later R9 complained of right hip pain when weight bearing and with range of motion. R9 told the CNA that she felt like her eyes were rolling back in her head then several minutes later R9 had no complaints. On 5/23/12 at 3:00 PM the nurses notes continued to state that the physician was notified of the fall and a new order was obtained for an x-ray of her right hip and a CT scan of her head without contrast. Review of the reports revealed the x-ray of the right hip and CT scan of her head had no acute findings. On 5/23/12 E11 (CNA) provided a statement of what occurred. E11 documented that she was in	F 309		

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F 309	Continued From page 4 the adjoining resident's room with the bathroom door open while R9 was at the sink getting dressed. While E11 was getting another resident dressed she heard R9 say she was closing the door. As E11 was walking towards R9 she was telling her no then she heard R9 fall. E11 walked in the bathroom and R9 was lying on her side under the toilet. E11 picked up R9 and put her back in her wheelchair. E11 continued to document that after she "got R9 situated she told the nurse what happened." On 8/7/12 at 2:10 PM interview with E2 (DON) and E3 (ADON) confirmed E11 failed to call the nurse to assess R9 before picking her up and putting her back in the wheelchair. E3 continued to state that E11 was a new CNA graduate. On 5/10/12 at 8:35 AM an interview was conducted with E11 who confirmed when R9 fell she picked her up and put her in a wheelchair before notifying the nurse of the fall.	F 309	**F323 Accident Hazards** **1. Corrective actions for affected resident** -Disciplinary action was taken with staff involved at time of incident. - Staff was in-serviced on gait belt use -Offered son for resident to be a Hoyer transfer which was refused. -Implemented nurse to be present for all transfers for this resident	5/4/12
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that for one (R5) out of 12 sampled	F 323	**2. Identification of other Residents** A review of all discolorations for the past 30 days will be conducted to ensure no other residents were affected. **3. Measures/System Changes** -Facility will re-inservice nursing staff on facility policy and procedure on gait belt use -will continue to include facility policy and procedure on gait belt use in new hire orientation	9/11/12 9/11/12

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F 323	Continued From page 5 residents the facility failed to use an assistive device during a transfer resulting in bruising to the resident. Findings include: R5 had a significant change minimum data set assessment (MDS) dated 3/5/12 that documented the resident required extensive assistance with transfers with two person physical assistance. R5's care plan for activities of daily living (ADL) level initiated on 7/20/11 with reviews on 10/27/11, 12/22/11 and 3/22/12 documented a two person transfer. An interview on 8/8/12 at 2:50 PM with two facility aides E4 and E5 revealed that gait belts are used with all resident transfers unless there is specific instructions not to do so. The facility's policy and procedure for Gait/Transfer Belt documented "It is the policy of this facility for all nursing personnel to utilize gait/transfer belts for resident transfers, ambulation and gait training. The gait/transfer belt provides a firm grasping surface for the staff person and protects the resident from accidental trauma". Review of the facility's incident/accident report for R5 dated 5/2/12 documented the presence of 10 inch by 5 inch yellow/green discoloration to the sternum with petechiae and an 8 inch full circumference of the left humerous pink/purple discoloration. The facility's investigation concluded that the resident was transferred by two aides without the use of the gait belt resulting in the bruising. The arm bruise being caused by a	F 323	**4. Monitoring** -Random weekly audits of transfers will be completed by the treatment nurse to ensure staff compliance with facility policy on gait belt use. - Results will be reported at weekly at risk meeting.	9/11/12

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 323	Continued From page 6 staff person holding the resident around the left arm and the sternum from the resident's right contracted hand pressing into the chest during transfer. On 8/9/12 at 9:20 AM interview with E2 (DON) and E3 (ADON) confirmed that all transfers are to be done with gait belt unless assessed by therapy or restorative nursing as not required. The facility failed to ensure staff utilized the assistive device (gait belt) for R5 which resulted in an improper transfer with bruising.	F 323	**F333 Significant Medication Error** **1. Corrective action for affected resident** -Education provided to evening supervisor who initially admitted resident and failed to identify discrepancy in discharge paperwork from hospital.	4/30/12
F 333 SS=G	483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS The facility must ensure that residents are free of any significant medication errors.	F 333	- Upon identification of error by administrative nurse, MD was promptly notified of error on April 29, 2012. - Disciplinary action was taken with day staff nurses involved in failing to notify physician of medication error.	4/29/12 5/1/12
	This REQUIREMENT is not met as evidenced by: Based on record review, review of the facility's policy and procedures, review of other facility documents and interview it was determined that the facility failed to ensure that one (R6) out of 12 sampled residents was free of a significant medication error. The facility failed to ensure R6 received the correct doses of Lantus insulin in accordance with the most current physician's order (Lantus is a long-acting insulin that works continuously to help improve blood sugar control for 24 hours. www.lantus.com). Administration of the incorrect doses of Lantus was a significant error which occurred on two separate re-admissions when R6 returned from the hospital on 4/25/12 and 4/28/12. These errors lead to R6 receiving significantly higher doses of Lantus than ordered by the physician. This		- Disciplinary action was taken with night shift staff who did not verify order changes upon residents return from hospital - All licensed staff was in-serviced on medication errors and how to prevent them following incident **2. Identification of other residents** Audits are being completed on all admissions/re-admissions to determined that no other residents have been affected	5/8/12 5/3/12 9/11/12

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F 333	Continued From page 7 resulted in R6 having a hypoglycemic episode, significant change in status and being sent to the hospital 911 with a diagnoses of "Diabetic hypoglycemia with diabetes mellitus type II. Findings include: R6 was admitted to the facility from the hospital on 4/25/12 with diagnoses that included dementia with chronic obstructive pulmonary disease, deep vein thrombosis, delusions, chronic kidney disease, and diabetes mellitus. On 4/25/12 the facility received a preliminary report discharge summary by fax from the hospital timed 1:51 PM that was unverified and not signed by the hospital physician. This discharge summary contained a list of medication on discharge for R6 that included Lantus 40 units sub q daily. At 2:05 PM a Final Clinical Discharge Summary was faxed to the facility. This report documented under "Continue these Medications: "Insulin glargine (Lantus Solostar Pen) 14 units subcutaneous daily in AM before breakfast". The facility failed to identify the differences between these two summaries. E6 transcribed on R6's physician order sheet that was copied over to R6's MAR Lantus 40 units sub-q instead of Lantus 14 units sub-q. (It was later determined that the Lantus 40 units was a typographical error on a preliminary report that was corrected on the final report.) Review of R6's facility physician order sheet dated 4/26/12 revealed an incorrect order for "Lantus 40 units sub-q Insulin 7:30 AM" instead of "Lantus 14 units sub-q insulin 7:30 AM".	F 333	**3. Measures and System Changes** -Facility will re-inservice licensed staff on facility policy and procedure r/t medication errors, appropriate monitoring of resident in the event an error occurs to assure resident safety and correct identification of discrepancies and actions to be taken when noted. 9/10/12 -Assigned nurse will ensure any resident returning from hospital or outside facility with change in orders will have orders verified with PCP promptly 5/3/12 -Medication errors added to new hire orientation 5/15/12 -facility has implemented a 3 check system on all admissions/readmissions to identify discrepancies in hospital paperwork. First check is completed by admitting nurse, second check is completed by 11-7 nurse, and third check is completed by QA nurse. 5/2/12 -Any discrepancy will be promptly verified with MD.	

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F 333	Continued From page 8 Review of R6's MAR for April 2012 revealed on 4/26/12 and on 4/27/12 at approximately 7:30 AM R6 was administered Lantus 40 Units sub-q instead of Lantus 14 units sub-q. Review of R6's nurses notes revealed on 4/27/12 at 7:40 PM a CNA called the staff into the room. R6 was "moaning and no speech was noted". R6 was unable to follow direction. R6's vital signs were "temperature 98.1, pulse 47, respirations 18, blood pressure 198/100 oxygen saturation 93% on 2 liters of oxygen" and blood sugar was "73". R6 was "diaphoretic with pupils that were pinpoint and fixed, with movement that was sluggish in bilateral upper extremities, movements were at will not on request". At 8:00 PM R6 was sent to the hospital 911. Review of the Emergency Medical Service Report Record revealed R6 had a change in mental status and a blood sugar of 38. R6 was administered 1 ampule of D50 (Dextrose 50). R6 was in atrial fibrillation with a heart rate of 47 and blood pressure of 198/100. R6's emergency room hospital records documented that on 4/27/12 R6 was brought to the hospital for a change in mental status with low blood sugar. It continued to state that R6 had a blood sugar in the 30s and was treated with intravenous D50 1 amp. Review of the documented medications on this sheet revealed the hospital had incorrect documentation that R6 had received "Lantus 14 units sq in AM before breakfast instead of the Lantus 40 units". R6 returned to the facility on 4/28/12 at 1:30 AM with discharge instructions for Lantus 10 units sq	F 333	**4. Monitoring** -Results of the admission/readmission audit will be reported at the monthly QA meeting.	9/11/12

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F 333	Continued From page 9 in the AM. . Review of R6's MAR revealed that on 4/28/12 at 7:30 AM E10 (LPN) administered Lantus 40 units sub-q to R6. Instead of the Lantus 10 units as indicated in the hospital discharge instructions from earlier that morning. Review of R6's physician orders revealed on 4/28/12 at 1:40 PM the discharge instructions with the change for the Lantus 10 units sq in the AM was reviewed with the physician. However, this occurred over 6 hours after the Lantus 40 units sub-q was administered. Review of R6's nurses notes dated 4/28/12 at 1:40 PM revealed the physician was called and orders from the ER were verified. (The physician was not made aware that R6 received Lantus 40 units that morning.) At 6:09 PM the notes documented R6 refused dinner and her vital signs were within normal limits. At 6:17 PM R6's physician was called about a possible allergy (however there was not mention of the medication error). At 11:30 PM R6 was documented as alert. On 4/29/12 at 1:15 AM the nurses notes document R6 had a change in status. R6 was assessed as groaning, having clonic (alternately contracting and relaxing the muscles. Tabers Cyclopedic Medical Dictionary Edition 19.) and tonic activity, (muscular tension or contraction. Tabers Cyclopedic Medical Dictionary Edition 19.) activity, unresponsive, diaphoretic, blood sugar was 77, with an oxygen saturation of 81 and was on oxygen 10 liters per minute via face mask. R6 "was not still enough to get a blood pressure..." At 1:30 AM R6's blood sugar was "40" a bolus of D50 was given. R6 was sent to the hospital 911.	F 333		

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F 333	Continued From page 10 Review of statements written during the facility investigation and interviews conducted by the investigation unit revealed: -When R6 was admitted to the facility E6 (RN) transcribed the Lantus order from the preliminary report/discharge instruction instead of the final report/discharge instructions to R6's physician order sheet and MAR. The preliminary report had a typographical error for Lantus 40 units sub-q that was corrected on the final report to Lantus 14 units sub-q. E6 transcribed the Lantus 40 units to R6's facility physician orders for R6 that was carried over to R6's MAR -R6 was administered the Lantus 40 units. R6 had a hypoglycemic episode and was sent back to the hospital. The discharge instructions from the hospital stated to decrease the Lantus to 10 units sub-q daily. -When R6 returned from hospital E8 (RN) was R6's nurse and E7 (RN 11-7 supervisor) was the supervisor on duty. E7 nor E8 called the physician to change the Lantus order to Lantus 10 units. E7 stated she told E9 (RN day supervisor) about the decrease in Lantus in report, documented it on the 24 hour report and put it in the physician book. Both told E9 and E10 (LPN) R6's day nurse were told about the change in the Lantus and that the doctor was not notified. No one checked R6's record to see what time the Lantus was routinely given. On 8/10/12 at 6:10 AM this information was reviewed and confirmed with E7. -E10 checked R6's blood sugar on 4/29/12 before administering the Lantus 40 units. E10 thought	F 333		

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HARRISON SENIOR LIVING OF GEORGETOWN, LLC	110 W. NORTH STREET GEORGETOWN, DE 19947

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 333	Continued From page 11 the Lantus was to be decreased at night not in the morning. She did not realize that the Lantus was ordered for once a day in the morning only. E9 called the doctor and received an order for the Lantus change to 10 units and realized that Lantus 40 units was administered that morning. E9 and E10 became aware of the medication error. E9 and E10 stated that they did not notify the physician about the medication error. The facility's policy and procedures for "Medication Errors" stated "When it is determined that a medication error has occurred, the following is to occur: d. Provide care, monitoring, etc as needed to assure patient safety" Review of R6's clinical record and the staff's written statements with E2 (DON) and E3 (ADON) on 8/8/12 at 2:00 PM and again on 8/9/12 at 11:00 AM confirmed that the facility failed to accurately administer the correct doses of Lantus to R6. This resulted in R6 receiving a significantly higher doses of Lantus than what was ordered. Consequently R6 was sent to the hospital on two different occasions for Diabetic hypoglycemic episodes due to the administration of significant error in Insulin. The facility failed to have a system in place whereby all staff compared the most recent physician orders to the physician order sheet and medication administration record.	F 333	**F514- Records** **1. Corrective action for affected resident** Cross reference F333 **2. Identification of other residents** Cross reference F333 **3. Measure/System Changes** -Cross reference F333 - Staff will be in-serviced on difference between verified and un-verified orders received from discharging facilities. **4. Monitoring** Cross reference F333	9/11/12
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional	F 514		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 514	Continued From page 12 standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on record review, review of other facility documentation and interview it was determined that the facility failed to accurately document the correct dose of Lantus insulin that resulted in one (R6) out of 12 sampled residents receiving the incorrect dose of Lantus insulin. Findings include: Cross refer F333 On 4/25/12 the facility received a preliminary report discharge summary by fax from the hospital timed 1:51 PM that was unverified and not signed by the hospital physician. This discharge summary contained a list of medications on discharge for R6 that included Lantus 40 units sub q daily. At 2:05 PM a Final Clinical Discharge Summary was faxed to the facility. This report documented under "Continue these Medications: "Insulin glargine (Lantus Solostar Pen) 14 units subcutaneous daily in AM before breakfast". The facility failed to identify the differences between these two summaries. E6 incorrectly transcribed onto R6's physician order	F 514		

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F 514	Continued From page 13 sheet that was copied over to R6's MAR Lantus 40 units sub-q instead of Lantus 14 units sub-q. (It was later determined that the Lantus 40 units was a typographical error on preliminary report that was corrected on the final report.) On 4/26/12 and 4/27/12 R6 received the incorrect dose of Lantus 40 units sub-q at 7:30 AM. The error in documentation caused a medication error that was not identified by the facility. R6 experienced a hypoglycemic episode which required hospitalization and on 4/28/12 R6 was returned to the facility with a discharge instruction for Lantus 10 units. The facility failed to review R6's record for the administration time and the amount of Lantus she was receiving. The facility also failed to review R6's discharge instructions with the physician immediately upon return to the facility in order to document the correct dose of Lantus insulin for R6. Review of R6's physician orders revealed on 4/28/12 at 1:40 PM the discharge instructions with the change for the Lantus 10 units sq in the AM was reviewed with the physician. An order was received and R6's records including the MAR was changed. However, these changes occurred over 6 hours after the Lantus 40 units sub-q was administered and over 12 hours after R6 returned from the hospital after having a hypoglycemic episode. Review of R6's clinical record with E2 (DON) and E3 (ADON) on 8/8/12 at 2:00 PM and again on 8/9/12 at 11:00 AM confirmed that the facility failed to accurately document in R6's record the correct dose for Lantus. This resulted in R6	F 514		

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F 514	Continued From page 14 receiving a significant larger dose of Lantus that what was ordered. R6 was sent to the hospital on two different occasions for Diabetic hypoglycemic episodes due to the administration of the wrong dose of Insulin.	F 514		

DELAWARE HEALTH AND SOCIAL SERVICES
Division of Long Term Care Residents Protection

DHSS - DLTCRP
3 Mill Road, Suite 308
Wilmington, Delaware 19806
(302) 577-6661

STATE SURVEY REPORT

NAME OF FACILITY: Harrison House of Georgetown

DATE SURVEY COMPLETED: August 9, 2012

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
	An unannounced complaint visit was conducted at this facility from August 6, 2012 through August 9, 2012. The deficiencies contained in this report are based on observation, interviews and review of residents' clinical records and review of other facility documentation as indicated. The facility census the first day of the survey was one hundred and twenty-one (121). The survey sample totaled twelve (12) residents.	Disclaimer: Preparation and/or execution of the plan of correction does not constitution an admission or agreement by the provider or the provider's employees as to the truth of the allegations in the Statement of Deficiencies. The Plan of Correction is offered in mandatory compliance with the provisions of state and federal law. The corrective actions are implemented as remedial measures pursuant to law.
3201	**Regulations for Skilled and Intermediate Care Nursing Facilities**	
3201.1.0	**Scope**	
3201.1.2	**Nursing facilities shall be subject to all applicable local, state and federal code requirements. The provisions of 42 CFR Ch. IV Part 483, Subpart B, requirements for Long Term Care Facilities, and any amendments or modifications thereto, are hereby adopted as the regulatory requirements for skilled and intermediate care nursing facilities in Delaware. Subpart B of Part 483 is hereby referred to, and made part of this Regulation, as if fully set out herein. All applicable code requirements of the State Fire Prevention Commission are hereby adopted and incorporated by reference.** **This requirement is not met as evidenced by:** Cross refer to CMS 2567-L, survey date completed 8/9/12, F157, F309, F323, F333, and F514.	**Date of Compliance 9/11/2012** Cross refer to POC submitted for survey date 8/9/12, F1457, F309, F323, F333, and F514

Carole Daniels Administrator 9/6/12